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DCF and Its Lead Agencies Have Not Resolved Issues Related to Serving Commercially Sexually Exploited Children

at a glance

In 2016, 356 verified commercially sexually exploited (CSE) child victims were identified, more than the 264 identified in 2015. Many CSE children identified earlier—both children in child welfare dependency and those living in the community with family—have since been re-victimized, involved with the criminal justice system, or only attended school intermittently.

Issues with how Department of Children and Families (DCF) and Department of Juvenile Justice (DJJ) select children to screen as well as the screening tool itself may limit accurate identification of CSE child victims. We recommend DCF and DJJ evaluate triggering criteria to determine their predictive value, gather feedback from users about how to improve the screening tool, and validate it as soon as it is possible to do so.

Over half (62%) of CSE children remain in the community and are referred to voluntary, local services; however, no data is readily available on whether the children use these services. Recent legislation will require DCF to maintain information on all CSE children, not just those involved in the dependency system.

Group care is being used for dependency children due to the shortage of specialized placements. We recommend that DCF regions and lead agencies actively recruit new providers and foster parents, increase the capacity of existing CSE providers, and direct existing providers not currently serving CSE victims to begin doing so. DCF and lead agencies also should continue to gather data on the availability and effectiveness of placements for CSE children.

Scope

Chapter 2014-161, *Laws of Florida*, directs OPPAGA to conduct an annual study on the commercial sexual exploitation (CSE) of children in Florida. We issued the initial report in June 2015 and the next annual report in July 2016.[1] This review reports on the number of children that the Department of Children and Families identified and tracked as victims of CSE; describes specialized services provided to CSE children; and presents short-term social outcomes for children identified in the 2015 and 2016 reports.

Background

Human trafficking takes several forms including commercial sexual exploitation

Human trafficking includes two types of exploitation: commercial sexual exploitation (CSE) and/or forced labor.[2] Florida law defines human trafficking as the exploitation of another human being through fraud, force, or coercion.[3] Florida law does not specify coercion as a condition of CSE, but defines it as the use of any person under the age of 18 for sexual purposes in exchange for or the promise of money, goods, or service.[4] Federal and Florida law both criminalize human trafficking of adults and children.[5]

[1] OPPAGA Report No. 2015-06 and OPPAGA Report No. 2016-04.
[2] Labor trafficking includes debt labor, bonded labor, and forced labor.
[3] Section 787.06, *F.S.*
[4] Chapter 2017-23, *Laws of Florida.*
[5] 22 USC 7102 and Ch. 2012-105, *Laws of Florida.*

In 2016, the National Human Trafficking Hotline received reports on 2,387 cases related to the trafficking of minors, 169 of which were located in Florida.[6]

Recent statutory changes further improve information about services for CSE children. The 2017 Legislature passed Ch. 2017-23, *Laws of Florida*, which clarified the definition of commercial sexual exploitation.[7] In addition, the law will require the Department of Children and Families (DCF) to maintain data on all CSE children, not just those involved with the dependency system. The law requires DCF or a sheriff's office to follow-up with all CSE children about services they received.

State, local, and federal entities have responsibilities in investigating child CSE and helping victims

State, local, and federal entities engage in activities to combat CSE in Florida. The Department of Children and Families investigates allegations of child CSE and provides for the child welfare needs of CSE children.[8] When DCF's child protective investigators identify youth involved in trafficking, DCF conducts an assessment about a child's safety, depending on the circumstances of the exploitation and the source of any danger threats to the child.

When a child protective investigator determines that a child's legal caregiver(s) have sufficient protective capacities to keep their child safe and can provide necessary care and supervision, DCF may refer the family to voluntary community services to provide needed support and resources during or at investigation closure. Children determined to be safe, but at higher risk, may be referred to community services and receive a service plan and case coordination services. For the purposes of this report, we will refer to CSE children who are eligible for these voluntary services as *community CSE children.*

When a child protective investigator deems a child unsafe in his or her home and judicial action is necessary, DCF submits a petition of dependency to the court.[9] When a child is adjudicated dependent, services from DCF are ongoing and non-negotiable. The child receives either an in-home case plan with case management or an out-of-home placement with case management. Throughout this report, we will refer to CSE children who have this status as *dependent CSE children.*[10]

DCF contracts with community-based care lead agencies (lead agencies) in all 20 circuits across the state to manage child welfare services, including services for CSE children who are adjudicated dependent or whose cases are still being investigated. Lead agency subcontractors provide on-going case management, emergency shelter, foster care, and other services as well as out-of-home placements in all 67 counties.

The Department of Juvenile Justice (DJJ) partners with DCF to identify CSE children brought into the delinquency system and to divert them to the child welfare system when possible. At delinquency intake, DJJ staff assesses all children and screens children who demonstrate indicators related to sexual exploitation. In addition, some of DJJ's prevention partners also screen for CSE. When appropriate, DJJ and its partners refer children to DCF.

The U.S. Department of Homeland Security, the Federal Bureau of Investigation, sheriffs' offices, and police departments investigate cases involving CSE children. Some local law

[6] This includes reports of both labor and sex trafficking.

[7] The Legislature worked on human trafficking issues as early as 2012. In that year, the Legislature passed the Florida Safe Harbor Act, which focused on rescuing and protecting sexually exploited minors, and providing specialized treatment and services, including residential settings referred to as safe houses. In 2014, the Legislature enhanced services for CSE children through Ch. 2014-161, *Laws of Florida*, further specifying the roles of state agencies and service providers in serving this population.

[8] In six counties, sheriff's offices perform child protective investigations. In addition, in certain circumstances or for unsafe children, lead agencies provide services to children.

[9] Section 39.501(1), *F.S.*, also allows any other person with knowledge of the facts of a child's case to file a dependency petition, not just the department.

[10] Our use of the term dependent is not exclusive to children processed through the court system. This group includes a very small number of unsafe children who may receive case management services and a case plan in the home without judicial action.

enforcement offices designate specific staff to conduct these investigations or to participate in regional human trafficking task forces.

The Florida Office of the Attorney General, State Attorneys, and U.S. Attorney's Offices across the state prosecute persons charged with trafficking children. Further, as directed by Ch. 2014-161, *Laws of Florida*, the Attorney General created and currently chairs the Statewide Council on Human Trafficking. The council's duties include developing recommendations for programs and services, making recommendations for apprehending and prosecuting traffickers, and developing overall policy recommendations.

In addition, the Office of the Attorney General makes funding available for CSE children and other victims.[11] In federal Fiscal Year 2016-17, Florida received $137 million in federal Victims of Crime Acts funding. The Attorney General's Bureau of Advocacy and Grants Management allocated this funding in grants to local agencies that serve crime victims, including human trafficking victims. The Office of the Attorney General also assists victims of human trafficking through its Bureau of Victim Compensation.[12]

Findings

A higher number of CSE children were identified in 2016

DCF verified 356 child victims of commercial sexual exploitation in 2016. Verified CSE cases increased from 264 in 2015 to 356 in 2016.[13] The higher number of verified cases could have resulted from improved surveillance and/or increased public awareness, rather than an increase in human trafficking victims.

During 2016, DCF's Florida Abuse Hotline received 2,013 reports alleging the CSE of children, which is a 57% increase over the 2015 reports.[14] Child protective investigators investigated 1,386 (or 69%) of those reports.[15] (See Exhibit 1.) Counties with the highest number of CSE reports include Miami-Dade (248), Broward (232), Orange (150), and Hillsborough (144). DCF hotline staff did not refer cases for investigation if the allegation did not rise to the level of reasonable (74%), there were no means to locate the victim (11%), or the alleged perpetrator was not the child's caregiver (8%).[16] Of the reports that were referred for investigation, most came from DJJ, the Department of Corrections, or criminal justice personnel (20%) and law enforcement (15%).

The DCF investigations resulted in verified CSE cases involving 356 child victims. Forty-three victims were verified in more than one

[11] This occurs via three mechanisms: providing grant funding to service agencies, reimbursing CSE children's families for certain expenses, and providing relocation assistance to human trafficking victims.

[12] This program provides reimbursements for certain expenses including mental health services for the CSE child victim (up to $10,000) and wage loss on the part of a parent who has missed work as the result of caring for the child (up to $15,000). The Bureau of Victim Compensation does not currently track CSE children separately from other victims, so the number of CSE children and their parents who received reimbursement as well as the types of expenses reimbursed is unknown. The bureau may also award relocation assistance to victims of human trafficking who have an urgent need to escape from an unsafe environment directly related to their sexual exploitation. Victims are eligible for a one-time $1,500 benefit paid out in two $750 payments. In Fiscal Year 2015-16, four minor victim applications were received; one was approved and received financial assistance.

[13] To estimate the number of allegations and subsequently verified CSE cases, we relied on DCF's Florida Safe Families Network data on hotline intakes and child protective investigations during 2016.

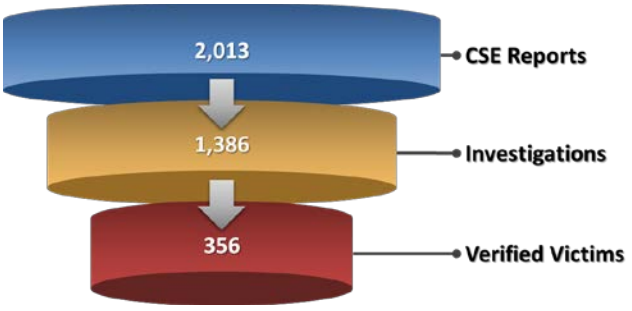
[14] The percentage change over time may be overstated to the degree that DCF may have not have captured all CSE hotline reports in earlier years. As described in OPPAGA's prior reports, DCF has made changes over time in the maltreatment categories used to capture human trafficking allegations which could affect 2015 hotline report totals.

[15] There were an additional 10 reports that were screened in under a general human trafficking maltreatment code, but these reports were not included in the analysis as we could not determine which reports were related to CSE, as opposed to labor trafficking.

[16] For typical child welfare cases, the caregiver must be the alleged perpetrator for the report to be referred for a child protective investigation; however, CSE cases warrant investigation regardless of the perpetrator's identity. DCF suggested that the 8% of cases screened out based on caregiver status could be due to hotline counselor error.

investigation. The counties with the highest numbers of verified victims included Broward (52), Orange (41), Miami-Dade (40), and Hillsborough (36). (See Appendix A for verified victims by county.)

Exhibit 1
Analysis of DCF Hotline Reports Identified 356 Verified Victims in Calendar Year 2016[1]



[1] Reported data may differ from information cited elsewhere by DCF or others for several reasons, including timing differences, selection criteria, and how investigations were counted.

Source: OPPAGA analysis of Department of Children and Families data.

The 2016 verified victims share similar demographic characteristics with victims identified in prior OPPAGA reports. Most verified CSE victims are white, female, and between 14 and 17 years of age. At the time of DCF's investigation, 86 CSE children were dependent and in out-of-home care. For these children, nearly half resided in a residential setting, such as group care, correctional facilities, and residential treatment, and over a quarter were on runaway status. An additional 37 children were adjudicated delinquent and entered out-of-home care as a result of their CSE investigation. Four children were receiving in-home dependency case management services at the time of their investigation, and 21 children received in-home dependency case management services as a result of their CSE investigation. (For an in-depth profile of CSE children's social characteristics, see Appendix B.)

In 2016, a higher percentage of CSE children remained in the community. Of the 356 verified CSE victims, 222 (62%) did not enter the child welfare system for services; this is a 9% increase from 53% in 2015.[17] In addition, 109 (31%) children received out-of-home services, 11 (3%) children received in-home services, and 14 (4%) children received in-home and out-of-home services during or as a result of their CSE investigation.

Issues with how DCF and DJJ select children to screen as well as the screening tool itself may limit accurate identification of CSE child victims

Experts agree that identifying CSE children is challenging, as they do not have immediately recognizable characteristics, many do not have identification, and they are often physically and/or psychologically controlled by adult traffickers. These cases are particularly difficult to investigate because CSE children rarely disclose or provide information on exploitation, and they may run away before an investigation is completed.

State law authorizes DCF to develop or adopt one or more initial screening and assessment instruments to identify, determine the needs of, plan services for, and determine the appropriate placement for sexually exploited children. However, DCF and DJJ may be unable to adequately identify these children due to problems with the process for determining which children should be screened for trafficking. In addition, neither DCF nor DJJ has validated the screening tool.

We recommend that DCF and DJJ evaluate triggering criteria to determine predictive value. Based on a review of the human trafficking research literature and input from stakeholders, DCF officials developed 15 criteria related to possible sexual exploitation that prompt staff to administer the human trafficking screening tool; any of the 15 criteria can trigger the comprehensive screening. In contrast, DJJ uses five indicators to trigger administration of the screening tool; four of the five are a subset of the DCF criteria and one is juvenile justice-specific. Any of the five is sufficient to trigger a screening.

[17] Concomitantly, the percentage of children served by the child welfare system has decreased from 47% to 38%.

DCF indicators include a history of running away or getting kicked out of their homes four or more times, a history of sexual abuse, presence of an older boyfriend, and presence of certain tattoos. Since the tool has been in place, DCF has not assessed the relative value of individual criteria or the usefulness of the 15 triggers overall. For example, some criteria may apply to many adolescents and not just CSE children, such as relationships with age-inappropriate boyfriends and/or girlfriends, or the presence of sexually suggestive material on social media sites.

In 2016, these 15 triggering criteria generated 1,025 DCF screenings.[18] However, DCF is not able to report an unduplicated count of how many children were screened or whether the screenings identified a CSE victim. Moreover, because DCF has not incorporated the screening tool into the department's electronic case management system, the department cannot review the triggering criteria's predictive value.[19] Child protective investigators (CPIs) we interviewed suggested that DCF may want to consider requiring a child to meet a combination of the triggering criteria, as opposed to any one criteria.

In 2016, DJJ staff conducted 3,447 screenings of 2,416 children, and made 1,542 reports to the Florida Abuse Hotline.[20] DJJ has incorporated the tool into its electronic Juvenile Justice Information System and tracks the number of completed screenings compared to resulting DCF hotline calls for monitoring purposes.

Without evaluating the criteria, DCF and DJJ have no way to know which triggering criteria are most useful and whether they are under-identifying victims or screening in too many children. Both agencies reported that they plan to review their respective criteria in the coming year.

We continue to recommend that DCF gather systematic feedback from users about the screening tool. In 2015, we recommended that the state agencies take steps to ensure that CPIs, case managers, and juvenile assessment centers properly and consistently use the screening tool. DJJ has sought systematic feedback from prevention providers who have piloted the tool and further reported during the course of our review that they are surveying juvenile assessment center staff to gather feedback about the instrument.

DCF reported that it plans to survey CPIs about the tool's implementation. We believe that feedback from primary users will aid the agencies as they decide what, if any, modifications to make to the tool. Some CPIs from high prevalence counties as well as certain lead agencies we interviewed consider the tool too long. It contains 52 questions in an 18-page document, so it is time-consuming and some feel that it detracts from efforts to establish a level of rapport that would lead the child to provide open and honest answers.

Another issue with DCF screening is that results are subjectively determined. Upon completing the tool, the screener assesses the likelihood that the child is a trafficking victim; the decision is not based on an objective score and there is little guidance to the screener on how to make this determination.[21] If the screener believes the child is involved in trafficking or is unsure, screening tool instructions require the screener to initiate a CSE investigation. In contrast, upon completion of the tool, the DJJ system prompts the screener when to call the hotline based on the child's answers to specific questions.

Subjective decisions may result in false positives or ambiguous findings. Inappropriately labeling a child as CSE can result in difficulty in placing the child and providing necessary services, as there are few CSE specialized placements.

We recommend that DJJ and DCF validate the screening tool when sufficient data and support are available to do so. Chapter 2014-161, *Laws of*

[18] This is DCF's estimated number of screening tools completed in 2016. These numbers were reported by each of the lead agencies.

[19] Screening tools are scanned into FSFN but not usable except for information about individual children.

[20] These numbers include screenings for suspected victims of both CSE and labor trafficking. While 56% of these calls were accepted by the hotline, 43% of the accepted calls were accepted for maltreatments other than CSE or labor trafficking (e.g., sexual abuse, sexual assault, or physical abuse).

[21] Administrators are asked to select a likelihood of "definitely not," "likely not," "not sure," "likely is," or "definitely is" a victim of trafficking.

Florida, requires the Human Trafficking Screening Tool to be validated, if possible. To date, that has not occurred. DJJ has automated the tool and may be able to validate the triggering criteria and the screening questions in the tool. DCF and DJJ reported that a greater number of screenings need to be completed before the tool is validated. Further, DCF reported that it cannot validate the tool without converting all the tool documents into a database or automating it.

Validating the screening tool is important to verifying the accuracy with which the state is identifying CSE children. Knowing which triggering criteria and questions are predictive of a verified finding could allow the agencies to shorten as well as improve the tool.

Once the tool is validated, the agencies may consider adding more systematic approaches to evaluating the results of the tool, such as setting up a scoring mechanism for the tool, as other DCF and DJJ assessments have. A scored screening tool, with directions for a screener on recommended next steps, would minimize the subjectivity of the tool results.

CSE children identified in prior years have not done well on short-term social outcomes; dependent and community children fared similarly

We examined the experiences of the CSE children identified in the 2015 and 2016 OPPAGA reports, which we will refer to as the *outcome population* in the following discussion. The outcome population includes 410 individuals who had verified findings of CSE from July 2013 through December 2015.[22]

We examined the outcome population's experience in three areas: criminal justice, education, and child welfare. Within these areas, we examined specific indicators, such as arrests, school attendance, employment, re-victimization, and family reunification or continued DCF supervision. Most commonly we assessed social indicators from the date the CSE investigation was received until the child turned 18.[23] This allowed us to capture some indicators for all 410 CSE victims, but some victims' information covered just a short period.[24]

Many CSE victims from the outcome population were involved with criminal justice agencies during the study period. We reviewed CSE victim encounters with the criminal justice system, including arrests, the most serious charges after their CSE investigation was received, and whether DJJ provided services. According to analysis of Florida Department of Law Enforcement and DJJ data, 244 (60%) of the 410 CSE victims were arrested at least once in Florida after the date their CSE investigation was received: 58% of community victims and 61% of dependent victims. One-hundred-and-fifty-three CSE victims found in DJJ's data were arrested more than once. Of the most serious charges associated with these arrests, aggravated assault was the most common, followed by simple assault or battery, larceny, and probation violations.

Within a year after their CSE investigation was received, 151 of the 410 victims in the outcome population (57% of the dependency group, 50% of the community group) had interaction with the

[22] We are referring to children identified in OPPAGA Report No. 15-06 and OPPAGA Report No. 16-04 for whom an investigation of CSE allegations was received by DCF between July 2013 and December 2015, and which ultimately resulted in verified findings of CSE. Some of these children appeared in both reports because they had subsequent findings of CSE. Individuals in the outcome population were all children at the time their CSE investigations were received, but may be adults as of the date we calculated these outcomes.

[23] In order to provide the most comprehensive information on social outcomes, we also capture and reported different start and endpoints, as appropriate. Depending on the data source, the data span ranges from the date the CSE investigation was received to December 31, 2016; for other social outcomes, we had an end date of April 1, 2017. In addition, for some social outcomes, the time period covers the date a child victim of CSE was first placed in out-of-home care to when that child turned 18. Finally, when possible, we measured outcomes for children over a fixed, equal outcome window (e.g., outcomes through the first year after children's CSE investigations for children for whom we had at least one year of information).

[24] For example, in DCF data, victims from the outcome population could be tracked from 24 days up to 1,361 days—an average of 557 days (or 18.1 months) depending on when the initial CSE occurred and how old the child was at the time.

juvenile justice system.[25] Some children received services in multiple DJJ programs and are counted more than once in the following service categories: 123 held in DJJ detention, 78 served through probation or community intervention programs, 33 in residential commitment, and 32 participated in diversion services.[26]

Many CSE victims from the outcome population struggled with attending and completing K-12 education. We also examined education outcomes for CSE children using Department of Education (DOE) information on current school enrollment, attendance, and grade level for the 2015-16 school year. (See Appendix C for more detail.)

We found K-12 school enrollment information for 277 of the 410 victims during the 2015-16 academic year.[27] These children attended several schools, resulting in multiple enrollments for some children. Attending multiple schools could be due to placement changes, especially if victims were moved to out-of-home placements or to and from DJJ programs. Of the total 419 school enrollments we identified for 277 children, 64% were for alternative schools such as DJJ residential facilities. Community CSE victims were less likely to be found in school enrollment records.

Further, 186 of 277 (67%) CSE victims in the outcome population were in a grade level that was lower than might be expected based on age. Over half of those below grade level were two or more years behind.[28] In addition, CSE victims attended school infrequently: 149 victims attended for less than half the academic year.

Few of the older CSE victims appear to have completed high school or received post-secondary education. Seventy-eight of the 277 CSE victims with K-12 education enrollments were enrolled in continuing education since the 2012-13 academic year; most of these enrollments were for remedial education.[29] Since the 2012-13 academic year, just 19 victims from the outcome population received a GED or diploma. We found very little difference between community and dependent CSE victims in educational attainment.

Finally, in 2016, 68 CSE victims in the outcome population who were 16 years of age or older worked at jobs covered by unemployment insurance during the first two quarters of 2016. About half of these jobs were in food service. Community CSE victims in the outcome population were more likely to have held a job, in part because they were slightly older than the dependent CSE victims in the outcome population.

The outcome population also fared poorly on child welfare indicators. Over half (52%) of the victims from the outcome population were the subjects of later DCF investigations of maltreatment. Through March 2017, 214 of the 410 victims in the outcome population had subsequent investigations, and 87 had verified findings of CSE.[30]

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[25] This total of 151 CSE victims includes some children who were already in DJJ programs at the time their CSE investigation was received or who may have just changed the DJJ program they were involved with post-CSE investigation.

[26] We did not count children who had been in DJJ's intake or prevention services.

[27] For academic year 2015-16, 133 CSE children had no K-12 or continuing education enrollment records. Five of these children were too young to enroll in school. The remaining children may be enrolled in school but not appear in the data for several reasons. First, the identifying information for the children in the outcome population may be inconsistent between DCF and DOE data. Second, enrollment records are not available for children who attended school out of state or attended private or home school. As a result, the counts of enrollments, attendance, and highest grade completed may be low. Further, some children may not be enrolled at all, particularly those whose age during this academic year exempted them from K-12 enrollment.

[28] Over- or under-age enrollment can occur for a variety of reasons and is decided by parents as well as schools. These results do not necessarily indicate underachievement. Case file reviews of community and dependent CSE children corroborated that CSE children often have poor school attendance.

[29] Two additional victims who completed K-12 education had continuing education enrollments during the same period. Continuing education data used in this analysis includes information about enrollments in Florida's public schools, public colleges and universities, and not-for-profit independent colleges and universities. We could not track CSE victim participation in for-profit colleges or institutes, such as culinary or cosmetology schools.

[30] We also examined 284 children from the outcome population who we could track for an entire year. Of those, 56 (20%) had verified findings of CSE in at least one investigation during that year.

Some CSE victims in the outcome population who had been placed in out-of-home care aged out of DCF's supervision. A total of 144 CSE victims in the outcome population had been placed in out-of-home care when the CSE investigation was received or entered it within six months of the CSE allegation being received. Because of the passage of time, 64 aged out of DCF's supervision by the end of the study period. In addition, 41 of the 144 victims were still in out-of-home care.[31] The remaining 39 victims were adopted, entered guardianship, or were reunified with their families.

As we reported in 2016, services for CSE victims were interrupted or not started because the children ran away, making it difficult to treat victims and evaluate the impact of treatment. The 144 victims from the outcome population who spent time in out-of-home-care after their CSE investigation was received averaged 9.6 changes in care (including disruptions due to running away, medical care, and visitation) per year. A total of 99 of 144 children (68%) had run away from out of home care after their CSE investigation was received. In general, the percentage of placements from which victims ran was the highest for group care and safe houses.[32]

Though they are 62% of CSE victims, little is known about community children and the services they receive

As in prior years, most CSE children identified in 2016 were community children. While dependent victims are often sent to residential services that typically include treatment, community children are referred to a range of voluntary, local services. The extent of CSE community children's participation in these services is unknown, however, recent legislation (Ch. 2017-23, *Laws of Florida*) will require DCF to maintain information on all CSE children not just those in the dependency system. This year we examined case files of a sample of community children to learn more about them.

Important differences emerged in the profile of community CSE children and their services. In 2016, 62% of CSE children were community children whose profile and service needs may differ from children in the dependency process. Community and dependent children are similar in terms of age (14 to 17), gender (female), and race (white). However, community children differ from dependent children in several important ways. We found 33% of community CSE children had previous verified maltreatment investigations, at the time of their 2016 CSE investigation, compared to 72% of children in or entering the child welfare system. Further, case files for community children showed they were more likely to be living with a biological parent who DCF determined to have sufficient capacity to protect a child from identified dangers. Therefore, they were not removed from their families and did not experience out-of-home care or in-home case management services.

Our case file review found that community children appeared less likely than dependent children to have a severe mental health diagnosis, to use narcotics or amphetamines, or to be involved in the juvenile justice system at the time of investigation. This is supported by Medicaid data, which suggests that some community children do have mental health and substance abuse diagnoses, but for less serious issues than some dependent children. (See Appendix D.)

In addition, the manner of community children's exploitation differs from that of dependent children. Community CSE children in the case file sample often arranged to exchange sex for money, apparel, or other goods independently (e.g., on social media websites) as opposed to many dependent children who were exploited through a third party, such as an older male acquaintance or relative.

[31] April 1, 2017.

[32] Running is not exclusive to CSE dependent children. The case file review shows that CSE community children also had a history of running away from home. Moreover, in interviews, lead agencies, CPIs, and providers suggest that running is a typical behavior for CSE children. Lead agencies and providers reported that the mobility of CSE children has a negative impact on their continuity of care.

The number of CSE community children who participate in services is unknown; there are several barriers to treatment completion. An unknown number of CSE community children receive voluntary services. To obtain additional information on services for community CSE children, we interviewed individual service providers. Some community service providers we interviewed had information on the number of CSE children they served, but did not track how many attended or completed treatment. There also was no indication of service duration or treatment completion in the case files we reviewed.[33]

During the course of an investigation, DCF policies require CPIs to convene a multidisciplinary staffing to make referrals for services that fit the particular needs of the CSE victim, and in the case of community children, services for their family as well, if deemed appropriate.[34, 35] DCF policy requires CSE child victims to be referred to the local child protection team.[36] These teams are often co-located with child advocacy centers and are typically the first to provide services. They may refer a CSE child to one of the 14 local Sexual Abuse Treatment Programs across the state; these programs provide family assessment, case management, and individual, group, and family therapy.

CPIs or lead agency prevention/diversion staff also may refer CSE community children to local providers, depending on a family's and child's needs, including community mental health and substance abuse providers. These providers reported that community CSE children receive crisis stabilization, trauma-informed counseling, enrichment therapies (e.g., art, music), case management, and harm reduction education; parents may be referred to parenting classes or respite services.

However, because CSE community children's services are voluntary, both the child and parent must agree to participate. According to community providers and lead agencies, a child's participation may break down at any stage in the therapeutic process. At the onset, the child and/or their caregiver may not agree to services. Some providers require that at least one family member also participate in therapy, and some parents may be unwilling or unable to do so. Further, therapeutic services are often provided at a clinic, not at a child's residence, and transportation may be an issue. Community providers also reported that because CSE children often do not see themselves as victims, they resist counseling, which makes for a long treatment horizon; children also may run mid treatment or otherwise stop participating.

Lacking CSE foster homes and safe houses, group care placement emerges as an option for some children; more information is needed on effectiveness

While community children remain under parental supervision, state law specifies the residential placements for dependent CSE children. Florida statutes require lead agencies to assess every verified minor CSE victim for placement in a safe house or safe foster home.[37]

However, instead of specialized placements in safe houses or safe foster homes, some lead agencies place CSE children in group and foster care with wraparound services. In 2016, 123 children who were either in out-of-home care at the time of their CSE investigation or entered care as a result of an investigation spent only 8% of their time in a safe house, a level unchanged from the prior year. (See Exhibit 2.) Compared to 2015, children in 2016 spent less total time in family

[33] CPIs closed these cases within 60 days in keeping with DCF standards.

[34] Participants in these staffings vary by region, and in addition to the CPI and a lead agency representative, may include the missing child specialist, the regional criminal justice coordinator, child protection team staff, or current providers may attend (Children and Families Operating Procedure (CFOP) 170-14).

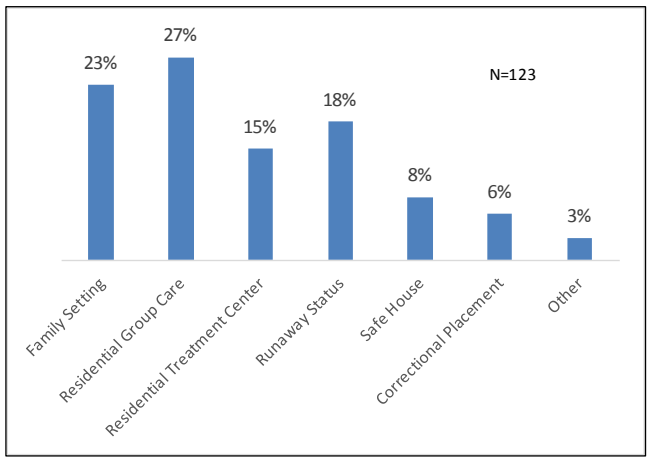
[35] In the case of CSE children who are dependent or who may be determined to be dependent, the team would assess appropriate placement options.

[36] CPIs must make a referral to the child protection team for any report alleging sexual abuse of a child (CFOP 170-5).

[37] Section 409.1754(1), *F.S.*

settings (23% vs. 30%) and more time in traditional group care (27% vs. 19%).[38]

Exhibit 2
CSE Dependent Children Spent Only 8% of Time in Safe Houses in 2016



Source: OPPAGA analysis of Department of Children and Families data.

Group care placements for CSE victims appear to have emerged as an option for several reasons including placement shortages and costs as well as the lack of active provider recruitment by DCF and the lead agencies. To ensure adequate treatment, DCF and the lead agencies should continue to gather data on the safety, availability, and effectiveness of placements for CSE children.

Lead agencies reported a pressing need for CSE residential services. To develop a full continuum of care for CSE victims, Florida needs to expand its current capacity. The number of CSE victims is far greater than the number of specialized safe beds. In 2016, there were 356 verified victims identified but only 28 safe house beds.

Prior OPPAGA reports found that safe house operators use admission criteria that exclude children based on characteristics that are typical of CSE children including pregnant or parenting girls, mental health issues not controlled by medication, or active substance abuse. As a result, many safe houses exclude the children they were selected to serve.

In addition, specialized care can be costly. As in prior years, in Fiscal Year 2015-16 lead agencies expended one-third more than their allocated budget for CSE children's services. During this period, expenditures totaled $4.2 million despite an allocation of $3 million.[39] Most lead agency expenditures, when compared with budgets, ranged from 110% to 1,464% of allocated funds, indicating that lead agencies used other child welfare funds to serve CSE children.[40] Several lead agencies reported that they primarily expend CSE funds to provide therapeutic programs or safe houses as well as safety services (e.g., one-to-one supervision or a single occupancy sleeping room) for children placed in residential group care settings.[41] (For detail on expenditures for specific lead agencies, see Appendix E.)

As shown in Exhibit 3, six providers accounted for 73% of expenditures for CSE children's services. Further, we observed that three behavioral health providers that may be used to stabilize and treat CSE children prior to being placed in a safe house or other setting accounted for 53% of expenditures for CSE children's services. Twenty percent of payments went to safe house placements, with charges often higher than $400 per day.

[38] To calculate percentage of time, we totaled time spent in every placement for all children from the CSE investigation intake date to the end of either the removal episode closest to the CSE investigation or the end of the follow-up study period (April 2017).

[39] Section 409.1678(5), *F.S.*, states that to the extent possible provided by law and with authorized funding, specialized residential options for children who are victims of sexual exploitation may be available to all sexually exploited children whether such services are accessed voluntarily, as a condition of probation, through a diversion program, through a proceeding under Ch. 39, *F.S.*, or through a referral from local community-based care or social service agencies.

[40] According to DCF, lead agencies may use any core services funding for CSE children. Core services excludes funding for independent living/extended foster care, maintenance adoption subsidies, protective services training, children's mental health wraparound services, and special projects. However, 5 lead agencies experienced deficits in core funding for Fiscal Year 2015-16, and 10 lead agencies have deficits in core funding for Fiscal Year 2016-17. According to DCF, the deficits are due to an increase in removals and a decrease in discharges resulting in an increase in the number of children in care.

[41] Safe houses are not Medicaid providers.

Exhibit 3
Six Providers Received 73% of the Funding for CSE Children's Services in Fiscal Year 2015-16

Provider	Total Payment Amount	Percent of Total Payments Statewide
Citrus Health Network	$ 927,260	22%
Devereux Advanced Behavioral Health	874,240	21%
Aspire Health Partners	405,694	10%
Porch Light	300,900	7%
Redefining Refuge	288,725	7%
Wings of Shelter	237,560	6%
Total	**$3,034,379[1]**	**73%**

[1] Remaining payments to other providers for services to CSE children equaled $1,125,589, and payments to all providers for services to CSE children totaled $4,159,968. The $2,042 difference between this figure and the total lead agency expenditures shown in Exhibit D-1 is due to cash versus accrual accounting methods.

Source: OPPAGA analysis of Department of Children and Families data.

Six lead agencies had unexpended budget for CSE children's services at the end of the budget year, including lead agencies covering areas of the state with a high prevalence of CSE victims, such as Broward and Hillsborough counties. (See Appendix E.)

The Legislature has appropriated an additional $8.1 million to CSE providers, but no new specialized treatment beds have been added. From 2014 through 2016, the Legislature appropriated $8.1 million to eight providers to serve and to develop or expand services for CSE children. Only $3.2 million has been spent. (See Exhibit 4.) No new beds have been added to date using this funding.

Exhibit 4
Funding to New Providers for Fiscal Years 2013-14 Through 2016-17 Remains Largely Unspent

Fiscal Year	Provider	Allocated Amount	Funds Expended
2013-14	Oasis	$ 300,000	$ 270,000
2014-15	Kristi House Drop-In Center	300,000	295,250
2014-15	Devereux	825,027	796,880
2015-16	Kristi House Drop-In Center*	476,912[1]	548,750
2015-16	Porch Light	50,000	43,419
2015-16	Devereux	359,000	261,399
2015-16	Bridging Freedom	1,000,000	174,960
2016-17	Devereux	359,000	256,429
2016-17	Kristi House Drop-In Center	200,000	148,500
2016-17	Place of Hope	200,000	152,213
2016-17	Dream Center	250,000	113,206
2016-17	Bridging Freedom	700,000[2]	0
2016-17	Voices for Florida - Open Doors	500,000	147,707
2016-17	Voices for Florida - Open Doors*	2,567,306	0
Four Year Funding Total		**$8,087,245**	**$3,208,713**

*Providers received federal Victims of Crime Act funds; all other funds are state General Revenue.

[1] This amount reflects combined state and federal funding; $250,000 in general revenue and $226,912 in VOCA funding. These funds are not specific to CSE child victims.

[2] This amount is recurring funding.

Source: OPPAGA analysis of Department of Children and Families and Office of the Attorney General data as of April 2017.

Providers expended funds for training, including foster parents, clinicians, and other service providers; direct services to CSE children; awareness and prevention efforts; program development; and facilities planning.

Two providers have been allocated nearly half of the funding but have not served any children. Open Doors and Bridging Freedom were allocated $3 million and $1.7 million, respectively.[42] Since the July 2016 allocation, Open Doors has been studying existing service

[42] Figures exclude $500,000 in Victims of Crime Act funding that Bridging Freedom decided not to pursue.

resources in anticipation of developing a referral directory and first responder network in five target areas.[43] However, while agencies who serve CSE children are generally aware of Open Doors, only informal discussions have taken place. To date, funds have been spent on salaries and travel for provider staff.

Bridging Freedom received initial funding of $1 million in July 2015 for developing a community-based safe house campus designed for residential treatment services for CSE victims. A fixed capital outlay agreement between Bridging Freedom and DCF went into effect February 22, 2016, with anticipated construction completion by February 28, 2017. In February 2017, the provider had not yet started construction. Delays were due to local permitting, environmental compliance requirements, and a lack of understanding regarding the use of state and federal funding.[44] In May 2017, the provider anticipated beginning construction in July 2017 and providing services in the spring of 2018.

We recommend that DCF and lead agencies take a more proactive role in new placement development. Florida statutes require each DCF region and community-based care lead agency to jointly assess local service capacity to meet the specialized service needs of sexually exploited children and establish a plan to develop the necessary capacity.[45] DCF operating procedures also require lead agencies and contracted service providers to design and deliver services that meet the needs of CSE victims placed in safe houses or safe foster homes.[46]

However, both DCF regional and lead agency staff see their roles as encouraging CSE placement development rather than active provider recruitment. DCF regional staff describes community partnership and interagency activities to facilitate and support providers who want to expand or develop new programs. Some lead agencies reported working to build partnerships to provide specialized services such as in-home therapeutic services, survivor mentor programs, and prevention services for CSE children.

While most lead agencies reported a lack of local, specialized CSE placements as well as difficulty placing CSE children, none reported that they have actively worked to develop local safe houses beyond making inquiries to the local provider community, though some provided support when providers came forward.

Safe foster homes are also limited. DCF reported there currently is one safe foster home in Florida. According to department regional staff and local lead agencies, the shortage of safe foster homes occurs in the context of a statewide foster home shortage. In addition, lead agencies and DCF regions reported several barriers to developing safe foster homes.

- The commitment required of a CSE foster family is high and only a subset of foster families is a good fit for a CSE child with intensive needs.
- A foster family that agrees to serve a CSE victim is no longer available to serve a non-CSE child in need of a similar level of intensive service.
- Some providers have a one-child-in-a-residence standard for safe foster homes, which limits the number of children a safe foster family can serve to a single child.
- One lead agency and one provider noted they prefer to place CSE children in female only foster homes as close male interaction may trigger CSE children's trauma and result in disruptive behavior.

[43] The 2016-17 General Appropriations Act stipulates services are to be initially provided in the Northeast, Big Bend-Panhandle, Central, Suncoast-Tampa Bay, and Southwest areas of the state.

[44] In 2016-17, Bridging Freedom was appropriated and applied for an additional $500,000 in Victims of Crime Act funding. However, the provider had not understood that this funding must be used for direct services to victims and could not be used for services related to the construction of their facility. When Bridging Freedom was informed of this requirement, they withdrew their application.

[45] Section 409.1754(2)(c)1, *F.S.*

[46] CFOP 170-14, 7. b.

Specialized placements may not be the best fit for all CSE children; group and foster care with wraparound services are used as an option for some. Lead agencies expressed uncertainty as to the effectiveness of safe house placements for all CSE children and reported that some children refuse to enter specialized placement because of safe house restrictions. In addition, while DCF has established a Treatment and Interventions Workgroup charged with identifying effective treatments, neither governmental nor other experts have identified best practices and a standardized CSE model of care.

Lead agencies reported that group and foster care with wraparound services can provide viable alternatives given the lack of availability and perceived fit of specialized placement options. The wraparound service model is well established for other populations, such as children's mental health services. Under this model, children are placed in regular group and foster homes with specialized services provided via contracted community providers.[47] Wraparound services compare to those received by CSE children in safe houses. Regular group care providers described making accommodations for CSE children that are in line with the child's service plan including placing them in a single room during the initial 90 days; restricting cell phones and internet access, including only supervised use of electronics; and additional staff assigned for one-on-one or close supervision.

The wraparound service model has some advantages.[48] As an established model for child mental health populations, it may work well for CSE victims who present with a variety of mental health conditions ranging from depression and anxiety to bipolar disorder. In addition, the model can use both existing and new providers, which allows lead agencies to serve CSE children locally, thereby providing continuity for the child and potentially greater lead agency oversight.

However, while wraparound services may provide more placement options for dependent CSE children, there are limitations to this treatment model. For example, statewide foster home shortages affect the placements available to CSE children. In addition, while some group care providers accept and make accommodations for CSE children, most group care providers do not accept them. Further, for dependent children with significant needs, the group care with wraparound services model may not be sufficient. To serve children with extensive needs, the lead agencies may use specialized therapeutic group and foster care.[49] These services provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting and are intended for children with moderate to severe emotional disturbances related to a psychiatric diagnosis.[50]

We recommend that DCF and the lead agencies continue to gather data on the availability and effectiveness of placements for CSE children. According to DCF, it is important to develop a full continuum of care that supports child welfare children in general and CSE children in particular. To address the shortage of placements for CSE victims, Florida needs to expand its current capacity. This requires a threefold approach: recruiting new providers and foster parents, increasing the service capacity of existing CSE providers, and encouraging existing providers not currently serving CSE victims to begin doing so.

If DCF and the lead agencies have evidence to support the effectiveness of regular placements with wraparound services for CSE children and the continued safety of other children in those placements, lead agencies should gather such information. In addition, DCF could gather

[47] Specialized therapeutic and regular providers, whether group homes or foster care, must receive training on CSE children prior to caring for this population.

[48] One of the largest CSE residential service providers in Florida, Citrus Health, provides wraparound services to CSE children in group homes and regular foster care via Citrus' CHANCE program.

[49] Citrus Health currently has 15 specialized therapeutic foster homes in their CHANCE program.

[50] A significant benefit of the specialized therapeutic group and foster care is that Medicaid covers some specialized services for children in these settings. Specialized services include twice weekly individualized, face-to-face therapeutic contact; coordination of care that includes linkages with the schools; primary medical care; community services; and substance abuse prevention, assessment, and treatment services.

information on the availability of those beds with existing providers in each region. For example, lead agencies could conduct a vacancy analysis with group care providers and foster parents and reach out to those providers to see if they would be willing to dedicate beds or a cottage to CSE children. This could save the infrastructure costs for constructing new provider facilities. Additionally, this would reduce placements out of region for children who would benefit from proximity to social networks and increase the lead agencies' level of oversight for these children.

Agency Response

In accordance with the provisions of s. 11.51(2), *Florida Statutes*, a draft of our report was submitted to the Secretaries of the Department of Children and Families and the Department of Juvenile Justice. The departments' written responses have been reproduced in Appendix F.

Appendix A

County-Level Prevalence Data

OPPAGA's analysis identified 356 verified child victims of commercial sexual exploitation (CSE) in 2016. Victims were identified in 42 counties; the majority were in Broward, Orange, Miami-Dade, and Hillsborough counties. (See Exhibits A-1 and A-2.)

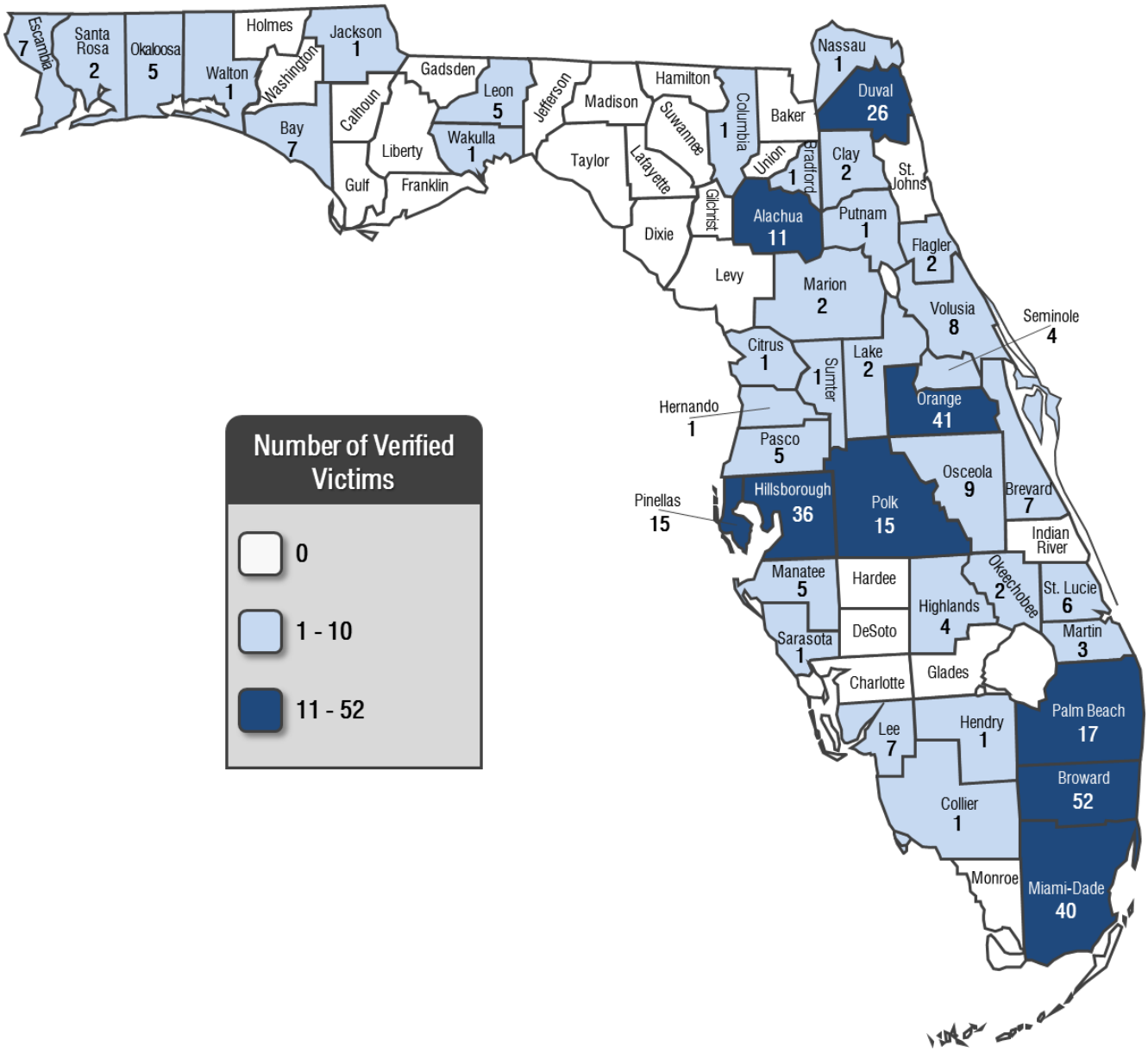
Exhibit A-1
Verified Victims of Commercial Sexual Exploitation

Community-Based Care Lead Agency	County[1]	Verified CSE Victims	Percentage of Verified CSE Victims
Big Bend Community-Based Care, Inc.	Bay	7	2.0%
	Jackson	1	0.3%
	Leon	5	1.4%
	Wakulla	1	0.3%
Brevard Family Partnership	Brevard	7	2.0%
Community-Based Care of Central Florida	Orange	41	11.5%
	Osceola	9	2.5%
	Seminole	4	1.1%
ChildNet, Inc.	Broward	52	14.6%
	Palm Beach	17	4.8%
Children's Network of Southwest Florida	Collier	1	0.3%
	Hendry	1	0.3%
	Lee	7	2.0%
Community Partnership for Children, Inc.	Flagler	2	0.6%
	Putnam	1	0.3%
	Volusia	8	2.2%
Devereux Families, Inc.	Martin	3	0.8%
	Okeechobee	2	0.6%
	St. Lucie	6	1.7%
Eckerd Community Alternatives	Hillsborough	36	10.1%
	Pasco	1	0.3%
	Pinellas	15	4.2%
Families First Network	Escambia	7	2.0%
	Okaloosa	5	1.4%
	Santa Rosa	2	0.6%
	Walton	1	0.3%
Family Support Services of North Florida, Inc.	Duval	26	7.3%
	Nassau	1	0.3%
Heartland For Children	Highlands	4	1.1%
	Polk	15	4.2%
Kids Central, Inc.	Citrus	1	0.3%
	Hernando	1	0.3%
	Lake	2	0.6%
	Marion	2	0.6%
	Sumter	1	0.3%
Kids First of Florida, Inc.	Clay	2	0.6%
Our Kids of Miami-Dade/Monroe, Inc.	Miami-Dade	40	11.2%
Partnership for Strong Families	Alachua	11	3.1%
	Bradford	1	0.3%
	Columbia	1	0.3%
Sarasota Family YMCA, Inc.	Manatee	5	1.4%
	Sarasota	1	0.3%
State total		**356**	**100.0%**

[1] Counties not listed did not have any verified victims during the study timeframe (though they may have had investigations). Counties presented above were the counties of CSE children's initial intake.

Source: OPPAGA analysis of Department of Children and Families data.

Exhibit A-2
Number of Verified CSE Children by County



Source: OPPAGA analysis of Department of Children and Families data.

Appendix B

Profile of Florida CSE Children

In recent years, increasing attention has been paid to the commercial sexual exploitation of children and to the lack of comprehensive and accurate national data collection on the characteristics and service needs of these victims. Despite the difficulties in compiling data, studies at the local level have shown that many of the children who are exploited have contact with multiple systems, including child welfare and/or juvenile justice, at some point in their lives. In addition, research reveals common environmental and individual characteristics that place a child at an increased risk for commercial sexual exploitation: child maltreatment; abandonment; previous sexual abuse; poverty; unstable home life; poor or disjointed family connections; chronic running away from home or a placement with increasing frequency and duration; a parent or caregiver's involvement in domestic violence; substance abuse (child and/or parents); and a child's emotional and school problems.[51]

Additional information below describes Florida CSE children and potential risk factors that we identified from analysis of automated Florida Safe Families Network (FSFN) data for 356 verified CSE children identified in 2016 and from 24 randomly selected case files of CSE children identified in 2015 with verified CSE who did not receive case management or other services through the child welfare system. When relevant, we compare the current case file information for community children to the prior year's case file information on 24 dependent children with verified CSE findings between July 2013 and December 2014 from DCF's FSFN.[52]

The majority of verified CSE children do not enter the child welfare system for services. The percentage of children who did not enter the child welfare system increased 9%, from 53% in 2015 to 62% in 2016. During this period, the percentage of children served by the child welfare decreased from 47% to 38%.

Most CSE children were living with a parent at the time of the CSE investigation. For children with available information on living arrangements, **59% lived with at least one biological parent** at the time of the CSE investigation. Community children were much more likely to be living with a parent, often a single mother, compared to children in the child welfare system. Based on investigative risk, danger, and family functioning assessments, community children's parent(s) had the ability, willingness, and capacity to keep their child safe and manage their vulnerabilities. Like dependent children whose files we reviewed in prior years, community children come from families struggling financially, have unstable family housing or living situations, and have parents with a history of involvement in the criminal justice system.

Nearly half of verified CSE victims had previous verified maltreatments. A child's prior history of neglect and abuse, especially sexual abuse, may be a risk factor for commercial sexual exploitation. Of the 356 verified CSE children, 47% (169) had at least one verified maltreatment prior to their first CSE investigation in 2016. For children who did not enter the child welfare system for services, 33% had at least one verified maltreatment prior to their first CSE compared to 72% of the children in or entering the child welfare system. The analysis showed slight variations in the type of prior maltreatments between community children and those in the child welfare system. Dependent CSE children are more

[51] *Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource for Child Welfare Agencies*, Child Welfare Capacity Building Collaborative, Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

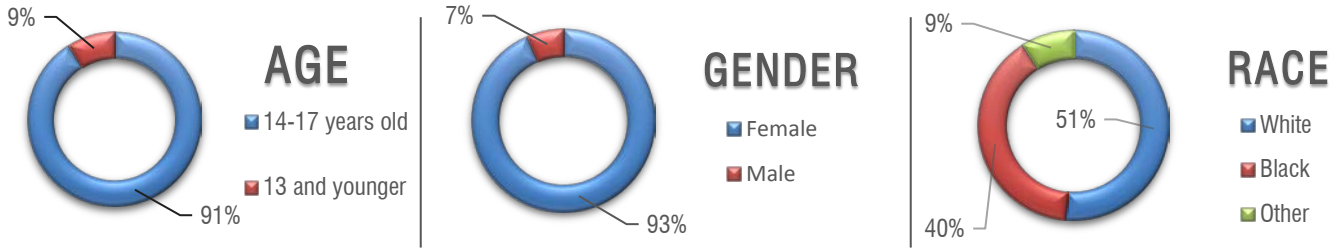
[52] *Placement Challenges Persist for Child Victims of Commercial Sexual Exploitation; Questions Regarding Effective Interventions and Outcomes Remain*, OPPAGA Report No. 16-04, July 2016.

likely to have prior verified maltreatments concerning parental substance misuse and the parents who lack the ability to protect the child; community CSE children were more likely to have prior maltreatments involving sexual abuse and physical abuse. In addition, the case file review found that, while many community children had family histories of maltreatment allegations and child protective investigations, the families did not have histories of adjudicated dependencies, voluntary or involuntary case management services, or out-of-home placements.

Children in out-of-home care who have been removed from their homes because of child abuse or neglect are at particularly high risk of being exploited. The U.S. Department of Health and Human Services cited a number of studies that found from 50% to over 90% of child CSE victims had been involved in the child welfare system. This finding was corroborated by an analysis of FSFN data that revealed 98 of 356 verified victims had prior in-home services and 130 had prior placements in out-of-home care. Twenty-two percent of community children received previous in-home or out-of-home services from the child welfare system, compared with 77% of children in or entering the child welfare system.

Exhibit B-1
Characteristics of Dependent and Community CSE Children

356 Children With Verified Findings of CSE During Calendar Year 2016 [1]



Compared to Dependent CSE Children, Community Children Have Characteristics That Make Non-Residential Services Feasible[2]

	COMMUNITY CSE CHILDREN	DEPENDENT CSE CHILDREN
Living Arrangement	• More likely to live with a biological parent • Parent(s) had the ability and willingness to care for the child and keep them safe	• More likely to be in non-parent and residential care than community children
Prior Maltreatment	• Most community children did not have verified prior maltreatments • Community children more likely to have prior maltreatments involving sexual abuse and physical abuse	• Most children in or entering the child welfare system had prior verified maltreatments; dependent children more likely to have prior maltreatments concerning parental substance misuse and parent's inability to protect the child
History of Services	• 22% of community children had previous in-home or out-of-home services • No family history of adjudicated dependencies, case management services, or out-of-home care	• 77% of dependent children had previous in-home or out-of-home services
Mental Health and Substance Abuse	• Fewer diagnoses of mental health or substance abuse issues prior to CSE investigation • Substance misuse primarily alcohol and cannabis • Less likely to be on psychotropic medication or to receive inpatient psychiatric treatment	• Case files showed incidence of mental health hospitalization, PTSD, depression, anxiety, mood disorders • Case files indicated use of amphetamines and narcotics in addition to alcohol and cannabis
Exploitation	• Fewer files showed community children were more likely to self-solicit or not have a pimp	• Dependent children were more likely to be exploited by a pimp or older adult

[1] OPPAGA analysis of DCF FSFN data.

[2] OPPAGA analysis of DCF FSFN data and case files.

Source: OPPAGA analysis of Department of Children and Families data.

Appendix C

For the 2015-16 Academic Year, Dependent and Community CSE Victims Had Similar Enrollment and Attendance Patterns

Exhibit C-1
CSE Children in the Outcome Population Are Enrolled in Schools, but Attend Infrequently and Are Not Completing K-12 Education

	Children With Enrollments 2015-16 Academic Year (N=277)		Children With Attendance Records 2015-16 Academic Year (N=270)	Children Age Eligible for Employment Year (N=305)
	Percent with an enrollment	Percent enrolled below expected grade level for age	Percent enrolled with an attendance record who attended less than half the year	Percent of age eligible children employed in first two quarters of 2016
All Age Eligible CSE Children With Education Information	72%	67%	55%	22%
Dependent CSE Children	81%	68%	57%	15%
Community CSE Children	66%	67%	54%	26%

Note: CSE outcome population is 410 individuals.

Source: OPPAGA analysis of Florida Department of Education data.

Appendix D

Many CSE Victims Also Received Services Covered by Medicaid

Medicaid, a joint federal and state program, provides health, dental, and mental health services to low-income individuals who meet income and asset criteria, including all dependent children. Other low-income children, including some CSE community children, may also be eligible for Medicaid.[53]

Most verified CSE children in the outcome population, 369 of the 410 victims, had a Medicaid ID, meaning that they may have received Medicaid services at any point in their lifetimes. Because dependent children are all enrolled in the Medicaid Managed Care Specialty plan, almost all of the dependent children (99%) had a Medicaid ID. In addition, 84% of the CSE community victims also had Medicaid IDs, which likely means that many CSE community victims may live in economically vulnerable families.

Many CSE children had claims proximate to their CSE investigation. Of CSE children with Medicaid ID, many also had Medicaid claims within six months after their CSE investigation was received. Eighty-one percent of victims in the outcome population who had a Medicaid ID had a claim within six months of the first CSE investigation.[54] When we compared the two CSE groups, 91% of the dependent children and 72% of the community children with a Medicaid ID had a claim within six months after the CSE investigation. We expected to see a high proportion of claims for dependent children, as foster care providers are required to bring children to the doctor, dentist, and any necessary behavioral health services. For community children, this high proportion could indicate that they or an involved parent helped them obtain services.

For CSE children who received any Medicaid services within six months of their CSE investigation, the most common Medicaid claims were for mental health and primary and specialty health care. (See Exhibit E-1.) We found that 198 of these children received mental health or substance abuse services from a community behavioral health provider or specialized mental health practitioner and 29 children were treated in an inpatient psychiatric hospital. To distinguish between mental health and substance abuse services, it was also necessary to review the primary diagnoses for which victims received services, rather than just the type of provider. We found that within six months of their CSE investigation, 219 victims had claims for services related to a mental health diagnosis and 68 victims had claims related to substance abuse diagnoses.[55]

In addition, a large proportion of the victims in the outcome population had claims for prescription medications. Of the victims who had a Medicaid claim within six months of their CSE investigation received date, 81% of CSE dependent children and 74% of CSE community children had claims for prescription medications. About one-third of the victims with a Medicaid claim within six months of their CSE investigation received date were given psychotropic drugs, many of which were anti-

[53] In order to better describe the array of services CSE children may receive, we analyzed Medicaid Statewide Medicaid Managed Care and Fee-for-Service claims for the 410 CSE victims in the outcome population. We matched CSE children's identifying information with similar information in the state Medicaid data system to determine if the child had ever had a Medicaid ID (during the study timeframe) and examined claims within six months of the date their first CSE investigation was received.

[54] By July 2013, Safe Harbor laws were in place that defined trafficking victims and some of the associated responsibilities of the Department of Children and Families. We would not have been able to identify children with verified findings of CSE until after that date, nor Medicaid services subsequent to those investigations.

[55] These claims include services provided by professionals who are not necessarily mental health or substance abuse specialists, such as hospitals, laboratories, and other physicians.

psychotic medications, selective serotonin reuptake inhibitors (depression and anxiety), and attention deficit disorder medications.

Exhibit D-1
Many CSE Children in Medicaid Received Behavioral Health Services Within Six Months of Their CSE Investigation Received Date

Medicaid Service or Provider	Percent of Dependent Children With a Claim	Percent of Community Children With a Claim	Percent of All CSE Children in Medicaid
Behavioral Health			
Treatment for Mental Health Diagnosis[1]	85%	61%	73%
Services From a Substance Abuse/Mental Health Provider[1]	78%	54%	66%
Treatment for Substance Abuse Diagnosis[2]	26%	20%	23%
Inpatient Psychiatric Hospital Treatment	14%	6%	10%
Physical and Dental Health			
Specialty Care Services	72%	66%	69%
Primary Care Services	73%	61%	67%
Hospital Outpatient Not ER Services	63%	59%	61%
Hospital Outpatient ER Services	60%	60%	60%
Dental	52%	16%	35%
Reproductive Health Provider Medical Service	32%	15%	24%
Hospital Inpatient Services	28%	17%	23%
Prescription Drugs and Support Services			
Any Prescription Drug	81%	74%	78%
Psychotropic Medication - Broader definition	45%	31%	39%
Psychotropic Medication	41%	29%	35%
Transportation	24%	25%	24%
Reproductive Health Prescription	28%	17%	23%

[1] These reflect services the child received that were related to a primary diagnosis of mental health and substance abuse. Those services may be provided by a provider whose primary specialty is not mental health or substance abuse, such as a primary physician, hospital, or laboratory.

[2] Services in this category include community mental health and substance abuse providers, not inpatient psychiatric hospitals.

Note: We omitted the "other" service categories or provider types from the chart above because of the breadth of diagnoses and treatments encompassed in that category, including the Child Behavioral Health Assessment and laboratory services.

Source: OPPAGA analysis of Agency for Health Care Administration data.

Appendix E

Lead Agencies Continue to Expend Additional Resources for CSE Child Victims Over and Above DCF Allocations

For Fiscal Year 2015-16, lead agencies expended one-third more than their allocated budget for CSE children's services; expenditures totaled $4.2 million with an allocation of $3 million. (See Exhibit E-1.)

Exhibit E-1
Lead Agencies Expended 139% of Their Budget Allocation for Fiscal Year 2015-16

Lead Agency	Counties Served by Lead Agency[1]	CSE Budget Allocation[2]	Expenditures of Fiscal Year 2015-16 Funds[3]	Percentage of Budget Expended
Big Bend Community-Based Care	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla, Bay, Calhoun, Gulf, Holmes, Jackson, Washington	$ 61,224	_	0%
ChildNet	Broward	505,102	$ 322,424	64%
ChildNet	Palm Beach	306,122	346,931	113%
Children's Network of Southwest Florida	Charlotte, Collier, Glades, Hendry, Lee	107,143	234,518	219%
Community Partnership for Children	Flagler, Putnam, Volusia	15,306	111,830	731%
Brevard Family Partnership	Brevard	30,612	329,020	1075%
Community-Based Care of Central Florida	Orange, Osceola	183,673	201,764	110%
Community-Based Care of Central Florida	Seminole	15,306	224,134	1464%
Devereux Community-Based Care	Indian River, Martin, Okeechobee, St. Lucie	61,225	55,750	91%
Eckerd Community Alternatives	Hillsborough	187,856	164,874	88%
Eckerd Community Alternatives	Pasco, Pinellas	210,104	106,624	51%
Families First Network	Escambia, Okaloosa, Santa Rosa, Walton	15,306	36,408	238%
Family Support Services of North Florida	Duval, Nassau	76,531	257,372	336%
Heartland of Children	Hardee, Highlands, Polk	183,673	360,981	197%
Kids Central	Citrus, Hernando, Lake, Marion, Sumter	61,225	29,300	48%
Kids First of Florida	Clay	-	-	-
Our Kids	Miami Dade, Monroe	841,837	937,099	111%
Partnership for Strong Families	Alachua, Baker, Bradford, Gilchrist, Levy, Union, Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	61,224	208,056	340%
Sarasota Family YMCA	DeSoto, Manatee, Sarasota	61,225	119,555	195%
St. Johns County Board of County Commissioners	St. Johns	15,306	115,370	754%
Total		$3,000,000	$4,162,010	139%

[1] Not all counties in a lead agency's service area have verified cases of CSE children.

[2] Based on DCF Budget Ledger System.

[3] Based on Fiscal Year 2015-16 Community-Based Care Lead Agency Monthly Actual Expenditure Reports including use of carry forward funds.

Source: OPPAGA analysis of Department of Children and Families data.

Appendix F

State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

June 28, 2017

R. Philip Twogood, Coordinator
The Florida Legislature
Office of Program Policy Analysis
And Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Coordinator Twogood:

This letter is in response to the preliminary and tentative findings and recommendations issued to the Department and Children and Families (DCF) on June 13th. The department is pleased that the information we provided to OPPGA regarding our human trafficking strategic plan has been reflected in the recommendations. The department has in fact already begun implementation of many of the recommendations and remains committed to identifying effective interventions for Commercially Sexually Exploited (CSE) children, and will continue its evaluation of existing treatment and services.

Finding 1: A higher number of CSE children were identified in 2016.

Response: The department has spent the last several years conducting extensive training to teach frontline staff and the public how to recognize and identify potential victims of CSE children. We have had slightly more than one year of full implementation of the Human Trafficking Screening Tool (HTST). The comprehensive nature of the guided interview contained within the HTST, in addition to public education, are most likely the primary reasons for the increased identification of CSE victims. DCF will continue to train frontline staff and improve our response to the emerging trends within the human trafficking field.

Florida's response to CSE of children exceeds almost all other states nationally in scope and in the wide array of options available to victims for treatment and placement. Florida is recognized as a national leader in the fight against human trafficking and has provided technical assistance to other states seeking to replicate our innovative approach to serving child victims of human trafficking.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

The mission of the Department of Children and Families is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.

Finding 2: Issues with how DCF and DJJ select children to screen as well as the screening tool itself may limit accurate identification of CSE child victims.

Response: The assertion that the HTST limits accurate identification of CSE child victims lacks statistical data. Evidence to support this conclusion and a comprehensive analysis of all variables and factors are not provided.

The tool was designed based on the most recent literature reviews and academic studies and with the input of two academic institutions. Research from RTI International has assisted DCF in further streamlining criteria for use of the screening tool. The RTI International study is the only study of this size in the nation that assesses the CSE child population within the context of child welfare. The department will continue to use the data from this research to inform CSE policy decisions.

Within the state of Florida, there has been a notable increase in verified findings of human trafficking of children since the implementation of the tool. The OPPAGA report suggests that this increase in verified findings may be the result of increased education and awareness. Without clear evidence, a more accurate statement would be "The ability of the tool to increase the potential identification of CSE victims is still unknown."

Recommendation 1: We recommend that DCF and DJJ evaluate triggering criteria to determine predictive value.

Response: The department has met several times with the Florida Institute for Child Welfare (FICW). Based on the new trending data received from RTI International and an updated literature review, DCF has requested that RTI International make recommend-dations to narrow criteria for the tool.

Child Protective Investigators are trained to use the tool as a guided interview. It is a narrative to invoke conversation, not a script to be read to the child. They are trained ***not*** to read the tool to the child, but to establish rapport and gain as much information as possible for their investigation. Because only six percent of verified victims made disclosures, it is imperative that all of the possible circumstantial information be collected.

Recommendation 2: We continue to recommend that DCF gather systematic feedback from users about the screening tool.

Response: Since the tool is still relatively new, particularly for a victim population that has been the target of so little longitudinal research, we have always recognized the need for consistent communication with our front line staff regarding implementation. We met with Criminal Justice Coordinators in February 2017 for regional feedback regarding the HTST, and we requested that FICW draft a survey for our frontline staff to gain feedback on their impression of the tool. This information was conveyed to OPPAGA in emails dated May 15, 2017, and April 17, 2017.

Research from RTI International and coordination with FICW have allowed us to narrow the range of criteria, streamlining the tool and decreasing workload on staff. We have met with frontline staff and managers to get their feedback on the tool, and used those findings to collaborate with FICW to improve the tool's implementation.

Recommendation 3: We recommend that DJJ and DCF validate the screening tool when sufficient data and support are available to do so.

Response: Section 409.1754, Florida Statutes, indicates that a tool should be validated, if possible. In discussions with FICW, we have learned that it is unlikely that DCF's use of the HTST can be validated. The location, emotional state of the child, the interviewer, as well as other factors, cannot be standardized based on the crisis nature of the investigations. Based on conversation with DJJ and FICW, the department is focused on the reliability of specific questions in determining findings.

In addition, one of the main goals of the HTST for child protective investigators was to create a cultural shift. It was to assist the child protective investigator in identifying what evidence must be collected in a CSE case, specifically because these youths do not self-identify at a high rate. As a result, the HTST has become a guided interview tool to identify victims. The report notates the increase in verification rates for reports involving CSE victims. The goal of the HTST is to identify victims. Therefore, we believe the increase in the verification rates could be attributed to the investigators' use of the HTST. This has aided investigators in constructing cumulative cases rather than relying on a victim to disclose, which is very rare.

OPPAGA notes that the HTST does not give a child protective investigator clear direction to make findings. The tool is not the determining factor in making findings. The tool guides the child protective investigator through questions to collect evidence to assist in making their findings. It provides a framework for the investigation. DCF CFOP 170-4, the Maltreatment Index, provides definitions of maltreatments and information relevant to determining findings. In addition, any suspected human trafficking case must have a multidisciplinary staffing where subject matter experts participate and assist in determining findings, as well as service referrals and placement needs.

Finding 3: CSE children identified in prior years have not done well on short-term social outcomes; dependent and community children fared similarly.

Response: The department appreciates OPPGA's analysis of this sample. Additional information on the impact of specialized treatment, particularly that which demonstrates statistically significant impact on trauma markers can be located in "*Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation" (CHANCE) Pilot Study: Progress Report 4."* This report is dated May 12, 2017, and is a three-year longitudinal study of Florida's CSE youth conducted by the University of South Florida.

Finding 4: Though they are 62% of CSE victims, little is known about community children and the services they receive.

Response: Senate Bill 852 was passed during the 2017 Legislative Session and requires DCF to follow up with the parent or caregiver on or before the six-month period following a verified report for commercial sexual exploitation to gain information on service engagement. The new legislation was not in effect during the review period. Information will be provided to the department for community youth by the parent or caregiver on a voluntary basis.

Finding 5: Lacking CSE foster homes and safe houses, group care placement emerges as an option for some children; more information is needed on effectiveness.

Response: DCF will always prioritize the needs of the child on an individual basis. The wide array of placement and services available, which includes specialized placements, allows DCF to respond to the unique needs of each child. We must understand the scope and scalability of service response for this population.

Recommendation 4: We recommend DCF and lead agencies take a more active role in new placement development.

Response: Lead agencies have recruitment plans that address the need for placement development. Recruitment is actively occurring at events held throughout the state for new homes and foster parents. The department's human trafficking team routinely meets with individuals who are interested in providing services and connects them with existing providers performing clinical and residential services. The department works with lead agencies in each of the six regions to identify and address gaps in service. The department has built strong collaborative relationships with Open Doors and Bridging Freedom and provides ongoing technical assistance regarding operationalizing their program models.

Recommendation 5: We recommend that DCF and lead agencies continue to gather data on the availability and effectiveness of placements for CSE children.

Response: The department recognizes the need for complex analysis to identify the effectiveness of specialized placements and will continue to gather data and share all grant opportunities with researchers, CBC lead agencies, and providers.

In closing, analyzing, evaluating, and adjusting the tool has been an ongoing project for the last two years. The department and community-based care lead agencies will continue to strive to better serve this vulnerable population, resolving issues as they arise, and tackling long term challenges.

If you have any questions, please contact Traci Leavine, Director of Child Welfare Practice, at traci.leavine@myflfamilies or 850-717-4760.

Sincerely,

Mike Carroll
Secretary

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

Rick Scott, Governor **Christina K. Daly, Secretary**

June 23, 2017

Mr. R. Philip Twogood, Coordinator
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street
Tallahassee, Florida 32399-1475

Dear Mr. Twogood:

The Department has received and reviewed the preliminary findings and recommendations of OPPAGA's report titled *DCF and Lead Agencies Have Not Resolved Issues Related to Serving Commercially Sexually Exploited Children.* Please consider this letter the Department's official response to the preliminary Report, in accordance with subsection 11.51(2), Florida Statutes. The Department does not suggest modification to the Report with regard to the preliminary findings and recommendations relevant to the Department included therein.

A key goal of the agency is to increase identification of victims of human trafficking through staff training and youth screening and to connect victims to appropriate services. As the Report describes, DJJ has implemented an automated Human Trafficking Screening Tool to be used in all DJJ intake facilities, has worked to train staff to administer the tool using a victim-centered approach, and continues to monitor the use of the tool for potential process improvements. The Department is proud to assist in screening efforts and serve as a safety net for children not previously identified as victims of human trafficking.

DJJ is committed to ongoing improvement of the tool and continuing our work to address this population of youth. The Department is dedicated to further collection of data in hopes of future validation of the screening tool as you recommend and to better understand the scope of trafficking in Florida and the incidence of these youth within the delinquency system. Although more data is necessary for a full validation, the Department has begun analysis, as you recommend, of the overall predictive value of triggering criteria. This analysis should be complete in the next fiscal year.

Thank you for the opportunity to review your preliminary findings and Report.

Sincerely,

Fred Schuknecht
Chief of Staff

cc: Mr. Robert Munson, Inspector General, Department of Juvenile Justice
Ms. Meredith Stanfield, Director of Legislative Affairs, Department of Juvenile Justice
Mr. Eric Miller, Chief Inspector General, Executive Office of the Governor

2737 Centerview Drive • Tallahassee, Florida 32399-3100 • (850) 488-1850
http://www.djj.state.fl.us

The mission of the Department of Juvenile Justice is to increase public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services that strengthen families and turn around the lives of troubled youth.

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The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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Project supervised by Mary Alice Nye (850/717-0567)

Project conducted by Emily Leventhal, Drucilla Carpenter, Michelle Ciabotti, Cate Stoltzfus, Anne Cooper, Justin Graham, and Anastasia Prokos

R. Philip Twogood, Coordinator